DERMATOLOGY
ASSOCIATES OF ITHACA
Healthier Skin Since 1983

PATIENT PAPERWORK

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PATIENT PIN# _____

Patient Email: _____
(Your email will be used to set up your online patient portal)

Reason's for today's visit: (include location; duration of problem – i.e. weeks, months, years; symptoms, treatments tried) _____

How did you hear about us? ☐ Radio ☐ Newspaper ☐ Facebook ☐ Google ☐ Word of Mouth ☐ Other:

PATIENT HISTORY

Medical History: (please list all medical problems you have – i.e. diabetes, high blood pressure, cancer, etc.)

History of Surgeries: (include date, location and type)

History of skin problems: (Cancer, precancer, psoriasis, eczema, acne, other: include date, location and type)

Do you wear sunscreen? ☐ Yes ☐ No If yes, which type/SPF? _____
Have you ever had a blistering sunburn? ☐ Yes ☐ No If yes, how many? _____
Do you use a tanning booth? ☐ Yes ☐ No

Medication	**Dosage**	**Route** (eg. oral, injection)	**Frequency**

*Please attach additional medications if space provided is not enough.

Allergies: (list all medication allergies and reactions, e.g. rash) ☐ I do not have any known allergies

SOCIAL HISTORY

Who is your Primary Care Physician? _____

When was your last visit with your Primary Physician? _____

Smoking Status: *Please check the box that best fits.*

- ☐ Never Smoked
- ☐ Former Smoker
- ☐ Current Everyday Smoker _____ pack/day for _____ years
- ☐ Current Some Day Smoker _____ pack/day for _____ years

Alcohol Use: *Please check the box that best fits.*

- ☐ Do not drink
- ☐ Less than 1 drink/day
- ☐ 1-2 drinks/day
- ☐ 3 or more drinks/day

For patients over 65 years old:

Females: How many times in the past year have you had 4 or more drinks in a day? _____

Males: How many times in the past year have you had 5 or more drinks in a day? _____

What is your ethnicity (e.g. Caucasian, Asian, African American)? _____

Where did you grow up? _____

Which statement best reflects your wishes regarding advanced care recommendation?

- ☐ I want full cardiopulmonary resuscitation efforts to be made (Full Code)
- ☐ I do not wish to have a breathing tube, even if it is necessary to save my life (Do Not Intubate)
- ☐ If my heart were to stop, I do not wish to have chest compression or an automated external defibrillator to restart my heart, even if it is necessary to save my life (Do Not Resuscitate)
- ☐ I have a living will
- ☐ I have a Health Care Proxy, whose name is _____ and phone number is _____

What is your occupation? _____

If retired, what was your previous occupation? _____

What are your hobbies? _____

FAMILY HISTORY

Please check the following medical conditions that have occurred in your family and list the family members with the condition(s):

Melanoma	☐ Yes	☐ No	Family member(s): _____
Skin cancer	☐ Yes	☐ No	Family member(s): _____
Unusual moles	☐ Yes	☐ No	Family member(s): _____
Severe acne	☐ Yes	☐ No	Family member(s): _____
Asthma	☐ Yes	☐ No	Family member(s): _____
Hay fever	☐ Yes	☐ No	Family member(s): _____
Eczema	☐ Yes	☐ No	Family member(s): _____
Psoriasis	☐ Yes	☐ No	Family member(s): _____

DO YOU HAVE PRESCRIPTION DRUG COVERAGE? ☐ **YES** ☐ **NO**

If yes, please complete the following:

Rx Bin: _____

Rx Group: _____

ID#: _____

Preferred Pharmacy: _____

REVIEW OF SYSTEMS

Do you have:	Pacemaker	☐ Yes	☐ No
	Defibrillator	☐ Yes	☐ No
	An artificial heart valve	☐ Yes	☐ No
	Artificial joints within past two years	☐ Yes	☐ No
Do you require:	Premedication prior to procedures	☐ Yes	☐ No
	Antibiotics prior to surgical/dental procedures?	☐ Yes	☐ No
	If yes, please explain: _____		
Do you have:	Allergy to adhesive	☐ Yes	☐ No
	Allergy to topical antibiotic ointments	☐ Yes	☐ No
Do you take:	Blood thinners	☐ Yes	☐ No
Are you:	Pregnant or planning a pregnancy	☐ Yes	☐ No
	If yes, please explain: _____		
Do you have:	An allergy to lidocaine	☐ Yes	☐ No
	Rapid heartbeat with epinephrine	☐ Yes	☐ No
	Yeast infections with antibiotics	☐ Yes	☐ No
	GI upset with antibiotics	☐ Yes	☐ No
	Problems with bleeding	☐ Yes	☐ No
Do you have a history of:	HIV/AIDS	☐ Yes	☐ No
	Hepatitis B/C	☐ Yes	☐ No
Have you been diagnosed with:	Diabetes (DM)	☐ Yes	☐ No
	Coronary Artery Disease (CAD)	☐ Yes	☐ No
	Heart Failure (HF)	☐ Yes	☐ No
	Chronic Obstructive Pulmonary Disorder (COPD)	☐ Yes	☐ No

Influenza Vaccine: *Please check the box that best fits.*

- ☐ Received a flu vaccine this flu season
- ☐ Did not receive a flu vaccine this flu season due to medical reasons
- ☐ Did not receive a flu vaccine this flu season because I do not want one
- ☐ Have not received a flu vaccine yet, but will receive one this season

Pneumococcal Vaccine: *For patients 65 and older, please check the box that best fits.*

- ☐ Received a pneumococcal vaccine
- ☐ Have not received a pneumococcal vaccine